Alabama Medicaid Agency

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BOB RILEY
Governor

MIKE LEWIS
Acting Commissioner

March 17, 2003

Provider Notice 03-03

RE: Critical Care

In accordance with American Medical Association changes to CPT procedure codes for neonatal critical care, Medicaid is updating policy for the billing of critical care and neonatal critical care. These changes should facilitate care delivery and billing by providers of critical care services. These changes are effective for dates of service April 1, 2003 and after. If you have any questions, please contact Kim Davis-Allen, Director, Medical Services at (334) 242-5011 or by e-mail at kdavis@medicaid.state.al.us.

Critical Care
When caring for a critically ill patient, for whom the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care is considered a global service inclusive of all services directly related to critical care. These codes can only be billed for a recipient age 25 months and older.

Coverage of critical care may total no more than four hours per day.

The actual time period spent in attendance at the patient's bedside or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

RESTRICTIONS:

Procedure codes 99291 and 99292 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except:

- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care can not be billed.
- Procedure code 99082 (transportation or escort of patient), may also be billed with critical care (99291 and/or 99292). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.
- Procedure codes 99291 and 99292 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

Neonatal and Pediatric Critical Care

CPT Code	Description	Criteria
99293	Initial Pediatric Critical Care, 31 days through 24 months of age, per day, for the evaluation and management of a critically ill infant or	Not valid for ages 30 days or less, can be billed by any physician provider type

	young child.	
99294	Subsequent Pediatric Critical Care, 31 days through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child.	Not valid for ages 30 days or less, can be billed by any physician provider type
99295	Initial Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 30 days of age or less	Not valid for ages 31 days or older, can be billed by any physician provider type
99296	Subsequent Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 30 days of age or less	Not valid for ages 31 days or older, can be billed by any physician provider type

The pediatric and neonatal critical care codes (99293-99296) include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parental nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

Routinely these codes may include any of the following services, therefore these services should not be billed separately from the critical care codes 99293-99296: umbilical venous or umbilical arterial catheters, central or peripheral vessel catherization, other arterial catheters, oral or nasal gastric tube placement, endotracheal intubation, lumbar puncture, suprapubic bladder aspiration, bladder catherization, initiation and management of mechanical ventilation or CPAP, surfactant administration, intravascular fluid administration, transfusion of blood components (excluding exchange transfusions), vascular puncture, invasive or non-invasive electronic monitoring of vital signs, beside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the critically ill neonate/infant. Only one criterion is required to be classified as critically ill.

- Respiratory support by ventilator or CPAP
- Nitric oxide or ECMO
- Prostaglandin, Indotropin of Chronotropic or Insulin infusions
- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory distress in a pediatric admission requiring oxygen therapy with at least daily adjustment and $FIO2 \geq 35\%$ oxygen by oxyhood

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99293-99296 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps
- Initial history and physical or EPSDT screen may be billed in conjunction with 99293 and 99295. Both may not be billed. NOTE: One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.
- Standby (99360), resuscitation (99440), or attendance at delivery (99436) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes.

LIMITATIONS:

- Subsequent Hospital Care codes (99231-99233) cannot be billed on the same date of service as neonatal/pediatric critical care codes (99293-99296).
- Only one unit of critical care can be billed per child per day in the same facility. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Procedure codes (99293-99296) can only be billed in the NICU or ICU (Intensive Care Unit). If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU critical care codes to be billed again.
- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Transfers to the pediatric unit from the NICU cannot be billed using critical care codes. Subsequent hospital care would be billed in these instances.
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

Intensive (Non-Critical) Low Birth Weight Services

CPT Code	Description	Criteria
99298	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	May only be billed by a neonatologist
99299	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	May only be billed by a neonatologist

These codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas of medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parental nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99298-99299 except:

- Chest tube placement

- Pericardiocentesis or thoracentesis
- Intracranial taps

LIMITATIONS:

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician group regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

Mike Lewis

Mike Lewis, Acting Commissioner

Attachment

Distribution List:

Alabama State Medical Association
Medical Association of the State of Alabama
Alabama Hospice Association
Alabama Hospital Association
Alabama Nursing Home Association
Division of Health Care Facilities
Electronic Data Systems
Alabama Medicaid Agency Staff

REMINDER: All Medicaid recipients are required to present their Medicaid eligibility card and proper identification to a provider of medical services for verification of eligibility when seeking treatment or service under the Medicaid program.